

ACKNOWLEDGEMENT OF RECEIPT
Receipt of Employee Claim Form (DWC-1)

Employer Representative Instructions: Use this form to document each time you provide a DWC-1 to an injured worker. Provide injured worker with current Approved WC doctor list.

Injured Worker: Sign and return this form to the employer representative when a DWC-1 is provided to you.

Injured Worker:

On: _____ at: _____
(Date) (Time)

I received a Workers' Compensation Claim form DWC-1

Injured Worker Printed Name

Signature

Employer Representative:

Signature

Date

MEDICAL REFERRAL FORM

The following covered injured worker: _____ seeks treatment for their industrial injury. Please forward reports and invoices to Intercare Holdings Insurance Services, Inc. Phone 800-771-5454.

Employer:

Placer County Risk Management, 145 Fulweiler Avenue, Suite 100, Auburn, CA 95603.

Phone: (530) 886-2600 Fax: (530) 886-2609

cc: _____ Risk Management